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ABSTRACT

Descriptive and statistical information on school-based clinics are provided. A mailed survey to 68 programs operating 120 school based clinics yielded responses from 46 programs representing 79 clinics, a 69 percent response rate. Data were collected on patterns of student use, student demographics, services, finances, legal issues, policy initiatives, and legislative activities. The '68 operational programs in 30 states are listed. Two descriptive tables and three figures are included. (LMI)

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A Project of The Center For Population Options

School-Based

UPDATE

A CLOSER LOOK AT THE NUMBERS

By Sharon R. Lovick and
Renee Freedman Stern

SBCs ACROSS THE NATION

120 SBC Operational Sites

68 Programs operated by various organizations

30 States

61 Different Cities/ Communities

SBCs in 1988

1988 was a year of continued growth and consolidation for the school-based clinic movement marked by a 41% increase in the number of new program openings. Most notably this increase was coupled with a dramatic rise in state legislative activity. A number of states funded initiatives that were instrumental in broadening community awareness and served as the impetus for many new programs.

It was also a year of continuing controversy. The public debate surrounding the appropriateness of offering reproductive health services as a part of the school day erupted in a few communities. Some new SBC programs opted for alternative approaches to delivering family planning services in the school setting. However, established programs held fast to their commitment to provide contraceptives directly to sexually active teens. Local community acceptance remains central to these decisions.

41%

Update 1988 highlights many important aspects of school-based clinic programming. It should serve as a catalyst for increased community awareness, discussion, and action.

THE SURVEY

The Support Center/CPO has compiled descriptive and statistical information on school-based clinics since its inception in 1985. Such information includes new clinic locations, descriptions of school populations served, staffing patterns and component services. Each spring, the Center attempts to collect more detailed information about existing SBCs.

In the spring of 1988, the Support Center/CPO mailed a three-part survey to the 68 programs that were then operating 120 school-based clinics throughout the United States.* One part of the survey concerned SBC operations and services, a duplicate of the 1987 survey. In addition, programs received a questionnaire covering legal issues of concern to SBCs and one covering state policy initiatives relating to clinics. A total of 46 programs operating 79 clinics responded to the survey, a 69% response rate. (Not all clinics responded to every question. The total number of responses for each question is reported in the text.)

Mail surveys are notably difficult research instruments to administer successfully. Several factors contributed to the response rate. First, the survey reached clinics near the end of the school year, for many SBCs a period of transition marked by new or reduced staff and other changes. In addition, the three questionnaires together comprised a lengthy document, requiring a substantial commitment of time to complete. Second, many clinics lack accurate procedures for collecting data and were unable to respond to the survey. Programs also vary widely in the types of data they collect; thus, many responded only partially to the questionnaire. Finally, fourteen new clinics opened during the 1987-88 academic year and reported data based on only a few months of actual program operation. Despite the limitations, the survey responses provide important information about a majority of programs operating clinics. From this information we can draw some generalizations that add to the body of knowledge about the school-based clinic movement today.

* one program operating a single clinic has moved off campus since the time of the survey. Although it no longer meets Support Center/CPO criteria for SBCs (location on school property) we have included it in this study because it qualified at the time.

41%

The Clinics

A total of 120 clinics, administered by 68 programs, were operating in the Spring of 1988, in 61 cities in 30 states (see Figure 1). The majority of these clinics were in senior high schools (105); only 15 were in middle or junior high schools. There has been a 41% increase in the number of clinics over the last year, an even greater rate of expansion than in the preceding year.

Most of the programs that operate school-based clinics are administered by Departments of Public Health (29%), non-profit organizations (27%), hospitals/medical schools (20%) and school systems (18%). A few operate as satellites of community clinics (7%). These figures indicate an increased sponsorship of SBCs during the past two years by school systems, public health departments and non-profit organizations, while a smaller percentage are operated by community health clinics and hospitals/medical schools.

All SBCs are located in school buildings or on school grounds. The great majority (76%) are open 40 hours per week, and 96% operate Monday through Friday. A substantial majority (66%) are open during the summer, al-

STUDENTS: A PATTERN OF USE

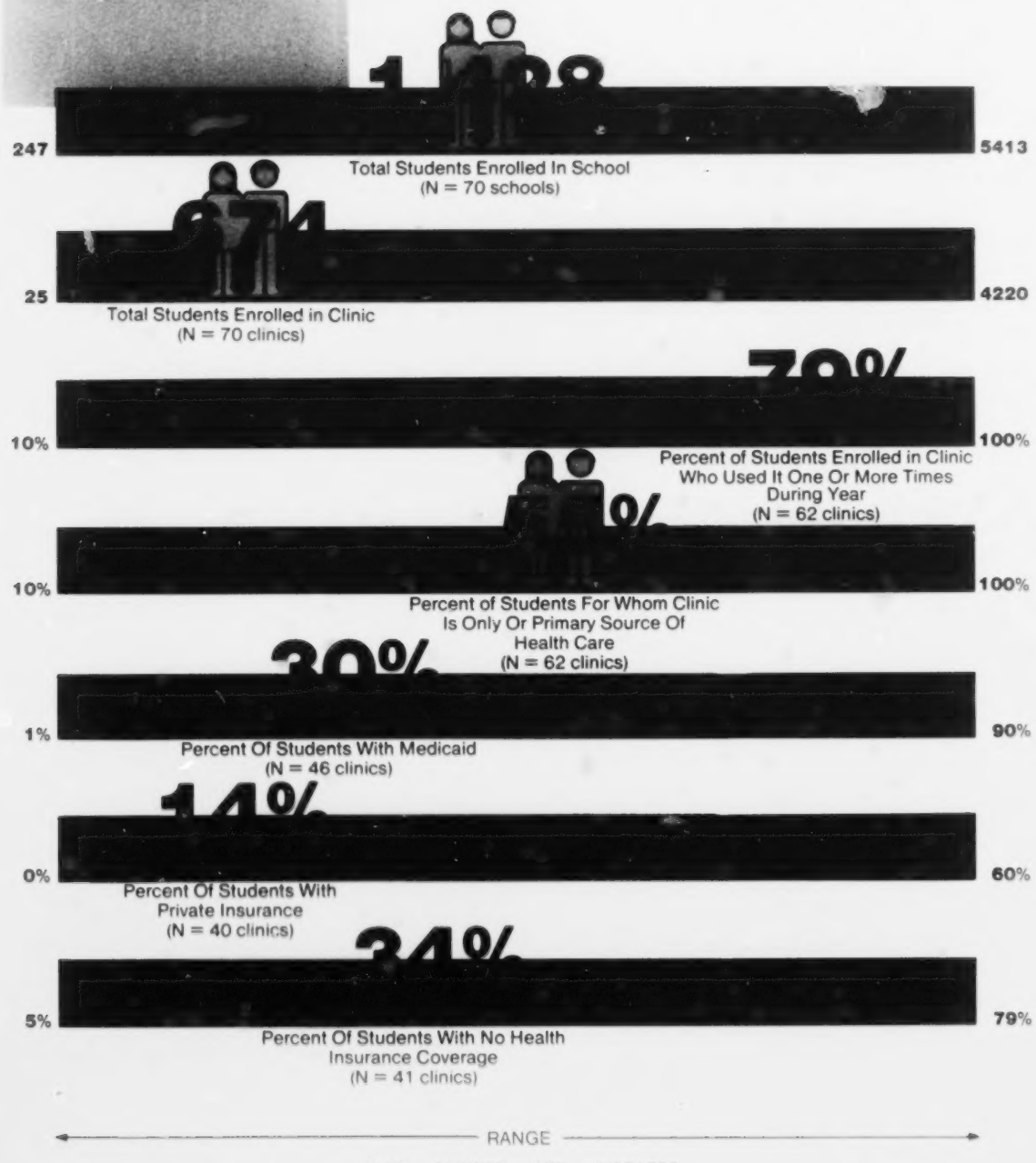

FIGURE 2

though few operate on school holidays. Clinics have a variety of arrangements for after-hours/emergency care: 36% arrange coverage with a community or public hospital, 22% arrange coverage by a SBC staff physician at a community site, and 10% have other arrangements. Nonetheless, 32% of the SBC programs responding to the survey have no coverage for after-hours care.

The majority of SBCs are located in schools with a school nurse (80%). One-fifth of these nurses work as part of the clinic staff. The majority refer students to the clinic while continuing to perform established school health functions.

79%

674

The Participants

The 120 schools with SBCs have student populations ranging from 247 to 5,413, with an average of 1,428. Clinic enrollment shows an equally wide range – from 25 to 4,220 – with an average of 674 students enrolled and thereby eligible to use clinic services. (See Figure 2.)

Among the 70 clinics reporting enrollment data, a total of 47,195 students are enrolled in clinics in schools with a total population of 99,947. This represents an enrollment rate of nearly 50%. Clinics estimate that 79% of enrolled students used the SBC one or more times during the year.

Clinic users reflect the racial and ethnic make-up of the schools they attend (Table 1). As the ranges indicate, the racial composition of the schools is varied – some are predominantly black, others are predominantly white or Hispanic. However, schools with clinics are more likely to have a high minority population because SBCs typically serve low income areas, and these tend to be disproportionately populated by minorities.

On average, 38% of clinic users are male and 62% are female. Over one-third of the clinics serve patients other than students enrolled in the home school. Among those receiving services are dropouts, adolescents in the larger community area, and siblings and children of students.

Clinics report that 55% of their users have no other primary source of care. In some programs this is true for almost 100% of enrollees. On average, only 14% of students who used SBCs had any form of private insurance; 22% were members of HMOs and 30% were covered by Medicaid. Thirty-four percent had no public or private medical coverage of any kind. (See Figure 2.)

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The Services

Each month the average clinic handles approximately 210 student visits. The range is wide – from 15 visits per month at a small SBC in Albuquerque to over 674 in Dallas.

Clinics continue to offer a comprehensive range of services (Table 2). However, there have been several notable changes in services during the past year. Overall, clinics are offering a greater variety of services. One of the most substantial increases is the number of SBCs providing management of chronic illnesses (up 16%).

But the most obvious change in services in 1988 is the declining percentage of programs offering reproductive health care. In particular, substantial drops have occurred in the percentage of programs providing prenatal care, pregnancy counseling, and birth control methods. These declines reflect the fact that programs opening since the fall of 1987 are attempting to avoid controversy by simply limiting services related to provision of birth control methods. Established clinics continue to offer reproductive health services at previous levels.

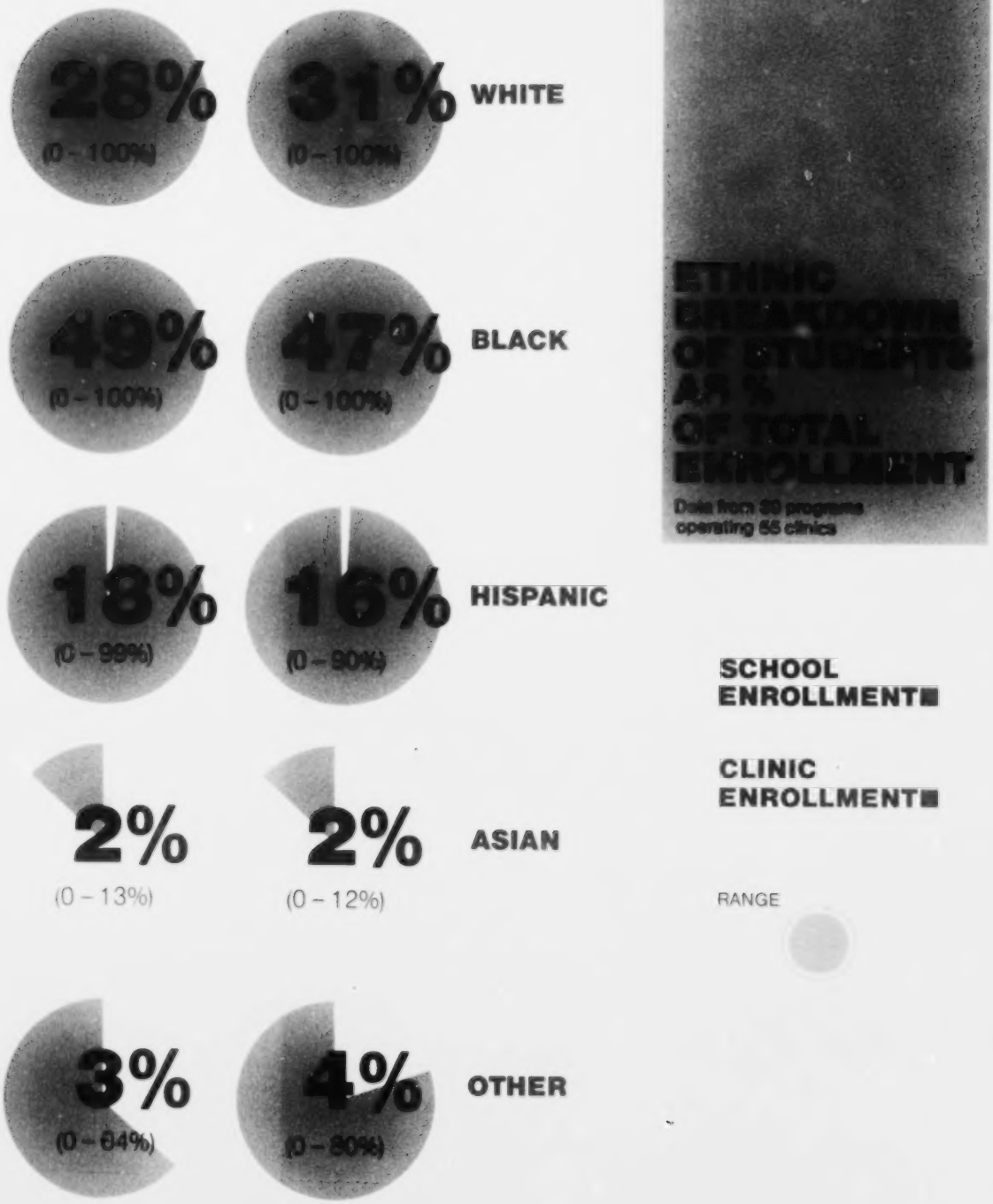

28%
(0 – 100%)
31%
(0 – 100%)
WHITE
49%
(0 – 100%)
47%
(0 – 100%)
BLACK
18%
(0 – 99%)
16%
(0 – 90%)
HISPANIC
2%
(0 – 13%)
2%
(0 – 12%)
ASIAN
3%
(0 – 84%)
4%
(0 – 80%)
OTHER
ETHNIC BREAKDOWN OF STUDENTS AS % OF TOTAL ENROLLMENT
Data from 30 programs operating 55 clinics
SCHOOL ENROLLMENT
CLINIC ENROLLMENT
RANGE

TABLE 1

PERCENTAGE OF SITES PROVIDING A VARIETY OF SERVICES

N=79 Clinics

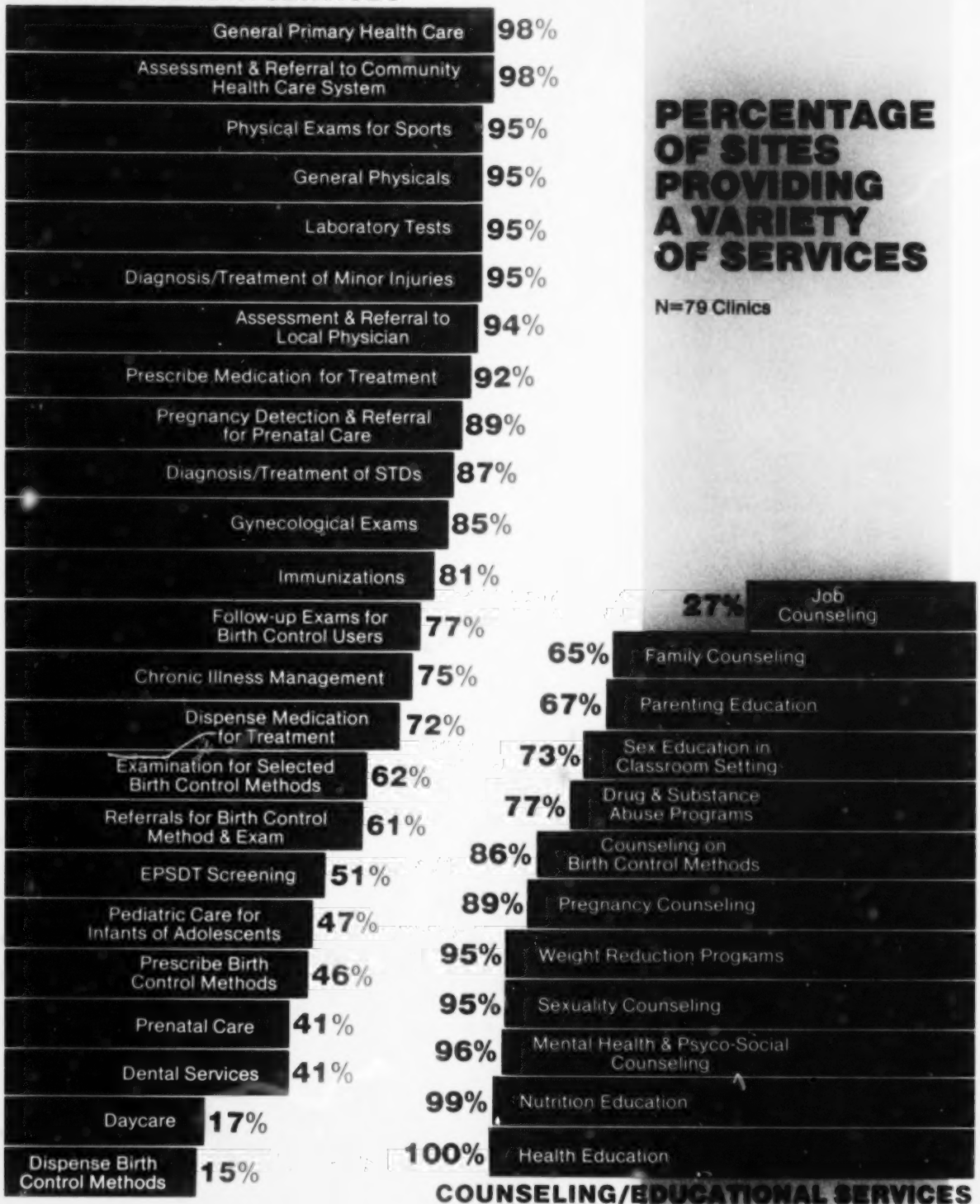


TABLE 2

A decline was also noted in the percentage of programs offering EPSDT screening (51% vs 60%). This drop is due to the difficulty of pursuing third-party reimbursements.

A number of clinics listed additional services that they would like to provide. Most frequently mentioned were dental services, family counseling, and contraceptive services. The majority of reporting sites indicated that lack of funding or lack of school board approval prevented the offering of these services.

Because SBCs frequently refer students to the community health care system and to local physicians, follow-up on referrals is crucial. Survey results reveal that most clinics use several methods to follow-up on referrals. Most frequently SBCs schedule a follow-up appointment at the clinic, call the agency of referral and call the student. Among a number of other alternatives, some clinics require students or the agency of referral to mail back a referral form indicating completed visit information; some accompany students to their appointments; others call parents.

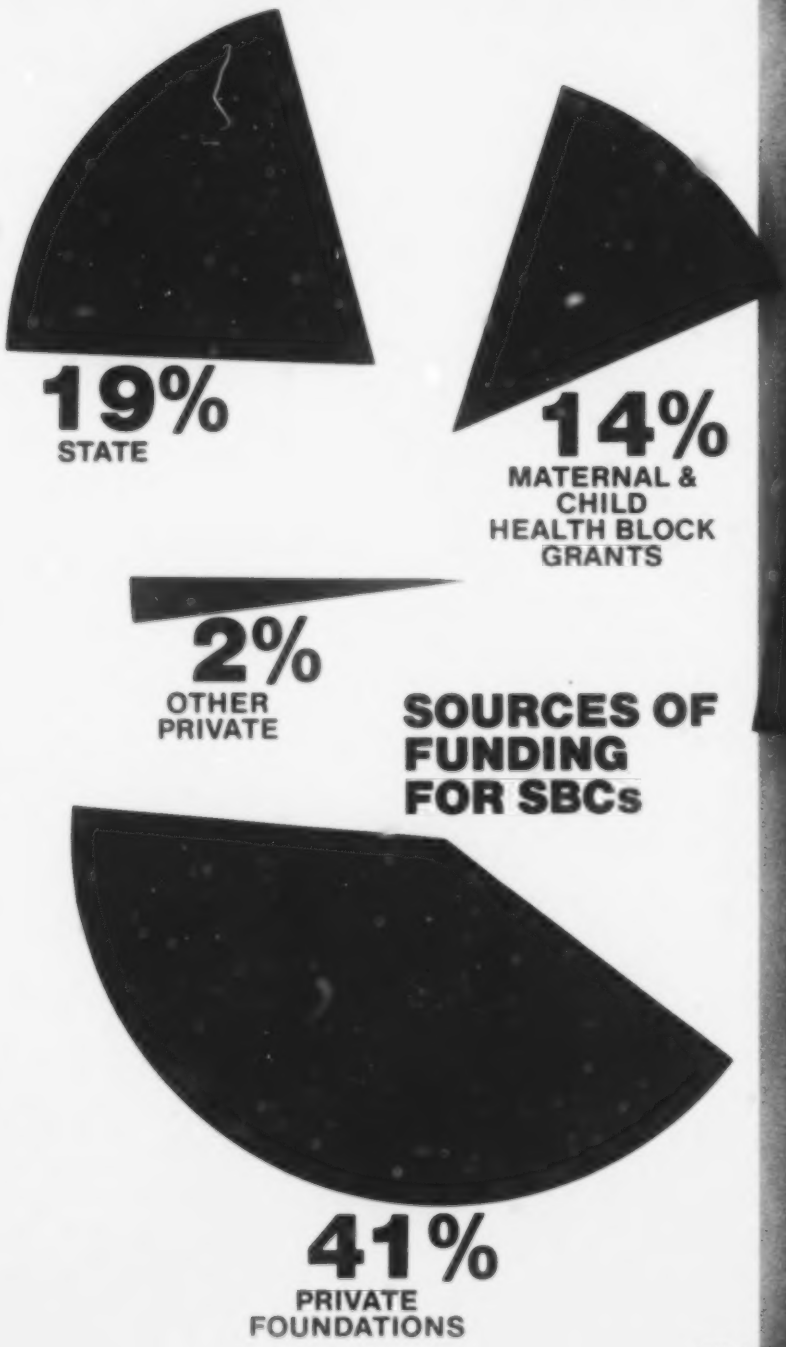
FINANCES

During the past two years a shift occurred in sources of funding for SBCs. In 1986, 31% of the total operating funds of school-based clinics came from private foundations; this year nearly 41% came from these sources. Among public sources of funds, the states were the largest contributors and the only public funders to have increased their share since 1986.

Figure 3 indicates the percentage of the total operating budget from each source for the 45 reporting programs (76 clinics) combined. Other sources of private funding included patient fees (.4%), private insurance reimbursement (.1%), and a combination of donations from private corporations, non-profit organizations and individuals (2%). Other sources of public funds included Early and Periodic Screening, Diagnosis and Treatment (2%), Medicaid (2%), Title XX (1%), and a combination of city and county health budgets, community health programs and others (19%).

All sources together contributed $9.2 million to school-based clinic programs. Nearly half of the programs (22) had a single source of income and an additional 9 had only two contributors. Only a single program relied on as many as six funding sources.

Operating budgets varied widely among clinics, ranging from $10,000 to $414,900. On average, the budget per clinic was $120,991. In-kind contributions are not included in operating budget figures because many programs were unable to give a dollar amount for in-kind resources. Of the 28 programs (operating 47 clinics) that reported them, in-kind contributions ranged from $2,200 to $213,219 with an average per clinic of $42,950. The combination of the average operating budget and average in-kind contribution results in an average total clinic budget approaching $165,000 per clinic per year.



TOTAL PUBLIC 57%

TOTAL PRIVATE 43%

N = 45 programs providing 73 clinics
Numbers are percentage of total operating funds from each source.

FIGURE 3

CONSENT/ CONFIDENTIALITY AND THE LAW

A number of legal issues are relevant to the operation of school-based clinics. In addition to questions of liability and informed consent that confront all providers of medical care, SBCs face the important and sensitive questions of consent and confidentiality in the delivery of care to minors. Because these issues are complex, the Support Center/ CPO and the National Center for Youth Law (San Francisco, CA) have produced a monograph detailing the applicable law and the range of practice among programs. Several important findings have emerged.

All SBCs responding to the survey report that they require parental consent for services; however, the consent form varies among programs. Almost all consent forms (93%) include a list of services; some allow parents to indicate which services their children may receive or those they may not receive. In some cases, only specific types of services are listed, for example, reproductive health services.

Although most SBCs require parental consent, some clinics provide services without consent under certain carefully delineated circumstances. Most frequently, SBCs waive the consent requirement for emergencies and for the treatment of emancipated minors. In some states, minors have a legal right to certain services such as family planning or other pregnancy related services, treatment of sexually transmitted diseases, treatment of drug/alcohol problems, and mental health counseling without notification of their parents. In these states, clinics are permitted to provide these services without consent.

The great majority of clinics (94%) consider information concerning services provided to the student as confidential. A slightly smaller percentage maintain patient confidentiality by requiring a signed release for disclosure of information from a student's record. However, clinics develop appropriate protocols to provide information without student consent in the case of suicide threats or threats to others, as well as to report on a student's general health status. Such information is most likely to be provided to a parent (39%), less often to a school nurse (22%) or a service provider from another agency (14%) and infrequently to school personnel (under 11%).

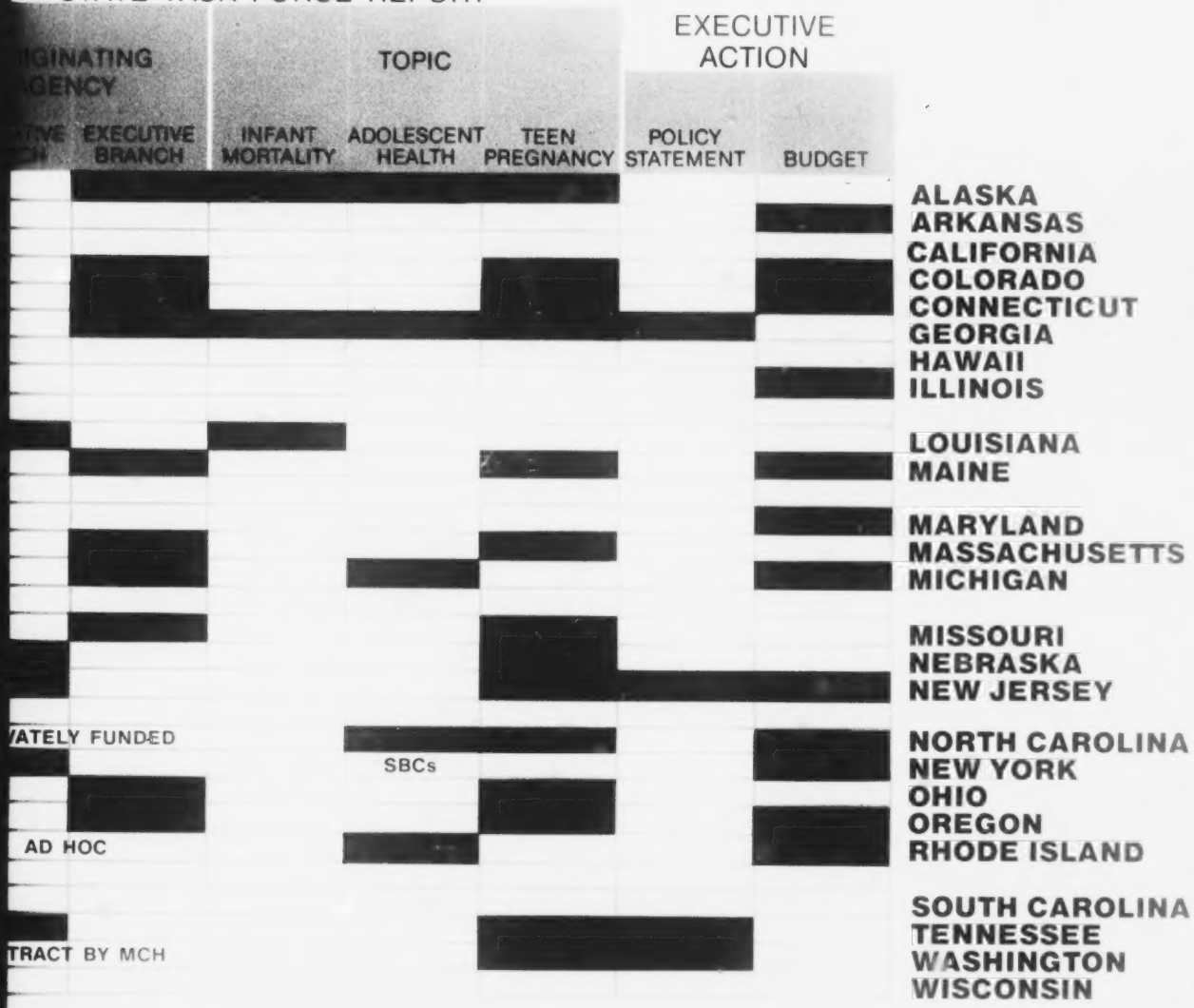
SBC POLICY INITIATIVES

There was considerable activity in 1987 in states around the country on issues related to adolescent health care (see Table 3). In the legislatures new bills tended to emphasize coordinating services with other programs and making schools a focal point for program efforts. Much legislative activity concerned topics tangential to school-based clinics, topics such as health and family life education, parental consent/notification for abortion services, provision of social services, teen pregnancy prevention, and services for pregnant and parenting teens. Fifteen bills dealing specifically with school-based health services were considered in 1987 (identical house and senate bills are not counted separately). Six were enacted. Of these six, three forbid distribution of contracep-

LEGISLATION STATUS

	BILL #		PASSED	VETOED	
ALASKA					
ARKANSAS					
CALIFORNIA	SB717	1	DIED		
COLORADO					
CONNECTICUT					
GEORGIA					
HAWAII	SCR97	1	DIED		
ILLINOIS	SB63	2	PENDING		
	HB925	2			
LOUISIANA	ACT904	2			
MAINE	HP802	1	PENDING		
	LD1076	1	PENDING		
MARYLAND					
MASSACHUSETTS					
MICHIGAN	H4280	2			
	H4283	1			
MISSOURI					
NEBRASKA	LB517	1	POSTPONED		
NEW JERSEY	A3345	2	DIED		
	S2451	2	DIED		
NORTH CAROLINA					PRI
NEW YORK	CH.198	1			
OHIO					
OREGON	SB485	1	DIED		
RHODE ISLAND	87H5011	1			
	87S11	1			
SOUTH CAROLINA	H2555	2			
TENNESSEE					
WASHINGTON	H955	1	DIED		CON
WISCONSIN	SB100	1			

STATE TASK FORCE REPORT



tives on school grounds (Louisiana, Michigan, and South Carolina). A Rhode Island law establishes a pilot SBC program, and laws in New York and Michigan provide funds for SBC programs.

While activity in the legislatures produced mixed results, reports from task forces studying teen pregnancy, adolescent health or related issues seemed to have reached a consensus. Fifteen of eighteen reports favored school-based clinics while only one came out against SBCs (Missouri). Two did not discuss school-based health services (Nebraska and Ohio).

Twelve states have budgeted funds at the state level for new or existing school-based clinics. The great majority of these are administered through State Departments of Human Resources or Departments of Health. Dollar amounts of funding vary considerably, with most states appropriating modest sums ($100,000–$500,000). New Jersey and Michigan, however, have made substantial commitments to SBCs.

There is wide variation among states in the level and success of activity surrounding SBCs. The following focuses on five states that represent a range of approaches to initiatives for school-based clinics.

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CONNECTICUT

In 1985 a special Task Force on Education to Prevent Adolescent Pregnancy produced a report that recommended action on school-based clinics. The Governor and General Assembly earmarked funds through the Department of Health Services to guide the implementation of clinics. Connecticut already had school clinics in operation; the Task Force recommended increased funding for existing clinics and development of new clinics.

In 1987, the State Department of Health Services (DOHS), continued to provide strong leadership for an expanding school-based clinic movement. The DOHS provided funding in the amount of $254,000 for seven existing clinics and offered six grants to communities for planning new clinics. That money is supplemented by funds from the federal Maternal and Child Health Block Grant Program, bringing the total program up to $472,000. In addition, clinics in New Haven and New London received additional monies in a newly established "Teen Pregnancy Prevention Community Grant," administered by the Department of Human Resources. This grant, established in 1987 legislation, will eventually fund projects in five communities. The terms of the bill suggest that school-based clinics be one component of a multi-pronged program.

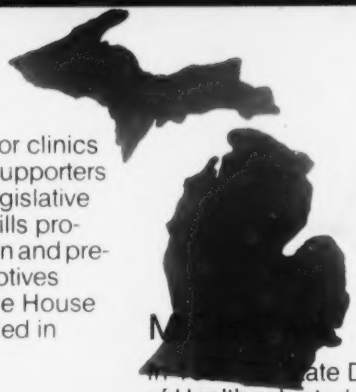
The strategy of offering seed grants to communities planning SBCs has been a constructive one in Connecticut, less fractious and more effective than attempting to establish an SBC program through legislation. State-funded SBCs in Connecticut do operate under certain restraints: DOHS policy prohibits the prescription or distribution of contraceptives on site, although counseling and referral are allowed.

State funding for FY 1989 is $416,200 and three additional clinics are scheduled to open early 1989.

ILLINOIS

Since the clinic at DuSable High School opened in 1985 in Chicago, SBCs have been the center of a highly visible battle over the issue of contraceptives in schools. The controversy continued throughout 1987.

A flurry of regressive bills threatened two SBCs with a prohibition against prescribing and dispensing contraceptives on site. One bill passed both houses of the Legislature; it was vetoed, however, by Governor James R. Thompson, who wrote: "I do not believe that HB 925 reflects the correct policy for the state of Illinois in this important and sensitive area." Governor Thompson rejected the bill on the basis of the principal of local control.



Community support for clinics has been high, and supporters have rallied during legislative assaults. Two more bills prohibiting the distribution and prescription of contraceptives were introduced in the House in 1988; both have died in committee.

If any restrictive legislation becomes law, three out of six of the Illinois SBCs would be forced to cut back services. All three Chicago clinics – DuSable, Orr and Crane – both prescribe and dispense contraceptives; the East St. Louis clinic prescribes contraceptives; PATH in Chicago refers students off-campus for contraceptives; the Kankakee clinic does not prescribe, dispense or refer.

It is obvious SBC opponents are on the offensive in Illinois. Nevertheless, SBC supporters have been successful in keeping the SBC program intact. In fact, 1987 appears to have been a year of consolidation, with two new clinics starting up (Crane in Chicago and the Kankakee clinic) and SBC administrators implementing a new data collecting system in the five clinics. State funding remained steady and rose to $730,000 in FY 1989. According to SBC supporters, no additional money will be available for new clinics. Right now, the goal is to maintain quality services at the six existing SBCs.

M

ate Department of Health adopted a five-year plan to develop adolescent health services, strongly emphasizing the role of school-based clinics. According to the plan 100 teen health centers (THCs) would be established during the five year period, making the Michigan plan one of the most expansive efforts in the nation.

In 1987, year two of the plan, the legislature reaffirmed its long-time commitment to THCs by appropriating $1.25 million to fund six existing and five new centers, as well as eleven seed grants for communities to assess adolescent health needs. The department is enthusiastic about the $2 million appropriated for fiscal year 1989, which provides for the continuation of eleven existing centers and the opening of five additional centers. These funds will also support eleven planning/community needs assessment grants.

Even as the Legislature showed its support for THCs through appropriations, it passed an amendment which circumscribes SBC services. The measure makes any person in a public school who prescribes or dispenses family planning drugs or devices guilty of a misdemeanor, punishable by 90 days in prison and a $500 fine. The measure was contested and ruled illegal on the grounds that it is unlawful to attach this sort of penalty to appropriations legislation.

Meanwhile, the Department of Health published two lengthy documents: THC program requirements and the final report of the state's adolescent health advisory committee. That report supported THCs as a viable model for addressing adolescent health needs. In her introduction to the report, then State Health Director Gloria R. Smith wrote, "... Media attention to teen health centers has been narrowly focused on the family planning component of these programs. Political opposition to (family planning) continues and is often based on misinformation. In Michigan and across the country, family planning services in teen health centers focus on delaying onset of sexual activity. Furthermore, they constitute a small percentage of the total service package ... Our young people are at risk today, and we need to take whatever interventions that seem beneficial to their well-being."

In addition to these activities, Department of Health staff developed a data system for use in THCs, making it easier to track program and user/service information.

Michigan is obviously devoting a considerable amount of state resources toward its THC program, with appropriations in the millions and substantial health department staff involvement. Worth monitoring, however, are the recent activities

of a group called the Family Life Alliance. The group appears to concentrate anti-THC efforts on communities which have received state seed grants, thereby attempting to keep additional THCs from being established.

NEW JERSEY

The Governor and General Assembly reconfirmed New Jersey's status as a leader in adolescent health care initiatives by allocating $6 million for a School-Based Youth Services Program that will fund approximately thirty program sites around the state. The Department of Human Services administers the program, which provides maximum grants of $250,000 a year to program sites. Even in the early stages, programs are reporting substantial use by teens, and monitoring evaluation activities are planned.

An important aspect of the New Jersey initiative is its truly comprehensive nature. All projects must offer a "core" of services, including job training and counseling and mental health as well as health services. Projects are encouraged to offer day care services, drug and alcohol abuse counseling, nutrition counseling, outreach to drop outs, and other counseling services.

Regulations preclude the use of state money to pay for contraceptives; however, centers, with local approval, may use other funding sources to provide such services. Approximately 65 percent of the projects which are receiving grants offer family planning services directly or through referral.

Meanwhile, on the legislative front, a House bill that would prohibit family planning services on school campuses was voted out of committee but never made it to the floor for a vote. A similar bill in the Senate was referred to the Education Committee, where it remained.

Local activists attributed success in part to strong leadership in the Department of Human Services. It appears that the strategy of working through the executive branch, concentrating on the budget process, has been successful in New Jersey. The Department of Human Services is looking ahead to the next two-year legislative cycle, and anticipates funding will continue.

OREGON

Passage of a bill in 1985 funding school-based clinics made Oregon the first state in the nation to establish an SBC demonstration program. That year the state's Health Division issued a request for proposals from communities developing comprehensive health services for teens.

In 1987 support for state-funded SBCs continued to build in Oregon, with the Legislature including $535,000 for five existing SBCs and one new SBC in its biennial budget. That amount is an increase over the previous allocation of $235,000, made in 1985. All of the SBCs are funded as three-year pilot projects; the original five are now entering their third year of operation. Not only is the Legislature supportive, but Governor Neil Golschmidt has also been speaking out in public about the benefits of SBCs. Plans for the 1989 legislative session include a request to fund 10 to 12 new clinics on a three-year pilot basis. Permanent funding for existing clinics will also be requested – an encouraging sign, since procuring long-term funding for clinics once pilot money has been expended is always difficult.

737

Federal Activity

SBC advocates have enjoyed some success over the last two years in educating federal lawmakers about the merits of the school-based clinic model. Although legislation (H.R. 1609 and S.737) that calls for demonstration funds for SBCs has thus far been unsuccessful, the Health and Environment Subcommittee of the House Committee on Energy and Commerce held hearings that were valuable in raising the level of awareness among members of Congress about the important services being provided in SBCs. Such awareness is necessary to increase the probability of federal funding in support of SBCs while preventing attempts to circumscribe services currently being offered.

SBCs ACROSS THE NATION

15 Jr. High/Middle Schools
105 Sr. High Schools

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New Detroit, Inc.
1 Kennedy Square, 10th Floor
Detroit, MI 48226
Celeste Rabaut
Director
JH 0; SH 2

St. Clair County Health Department
3415 28th Street
Port Huron, MI 48060
Dorothy Hicks-Burchwell
JH 0; SH 1

MINNESOTA

Health Start
640 Jackson St.
St. Paul, MN 55101
K.C. Spensley
Executive Director
JH 0; SH 5

Minneapolic Public Schools
254 Upton Ave. South
Minneapolis, MN 55415
Anne St. Germaine
Coordinator,
Adolescent Health
JH 0; SH 5

MISSISSIPPI

Jackson-Hinds Comprehensive Health Center
4433 Medgar Evers Boulevard
Jackson, MS 39213
Aaron Shirley, M.D.
Project Director
JH 1; SH 1

MISSOURI

Adolescent Resources Corp.
4010 Washington, #400
Kansas City, MO 64111
Gerard Kitzi
Executive Director
JH 0; SH 1

MONTANA

Lodge Grass Public Schools
Districts No. 2 and 27
Lodge Grass, MT 59050-0559
Joy Arneson
School Nurse
JH 0; SH 2

NEW JERSEY

Jersey City Medical Center
88 Clifton Place
Jersey City, NJ 07304
Joanne Lukomnik, M.D.
JH 0; SH 2

University of Medicine & Dentistry
of New Jersey
185 S. Orange Avenue
Newark, NJ 07103-2757
Robert Johnson, M.D.
Program Director
JH 0; SH 1

NEW MEXICO

University of New Mexico
Surge Building
Albuquerque, NM 87131
Sally Davis
Director,
Adolescent Care
JH 0; SH 5

Albuquerque Public Schools
P. O. Box 25704
Albuquerque, NM 87125
Alicia Snyder, RN
Liaison-SBC Nursing
JH 0; SH 3

Pecos Valley Medical Center
P. O. Box 710
Pecos, NM 87550
Virginia Hules
Director,
Medical Center
JH 0; SH 1

NEW YORK

St. Luke's-Roosevelt Hospital
428 West 59th Street
New York, NY 10091
Alwyn Cohall, M.D.
Medical Director
JH 0; SH 2

Mt. Vernon Board of Education
100 California Road
Mt. Vernon, NY 10552
Della G. Bryant
Director
JH 0; SH 1

Mt. Sinai Hospital - Adolescent Center
19 East 101st Street
New York, NY 10029
Leslie Jaffe, M.D.
Director,
Adolescent Health
JH 0; SH 2

William F. Ryan Community Health Center
160 West 100th Street
New York, NY 10025
Dean LaBate
Director,
Adolescent & Womens Health Clinic
JH 0; SH 2

Center for Population & Family Health
60 Haven Avenue, Floor B-3
New York, NY 10032
Lorraine Tiezzi
Director
JH 2; SH 0

North Shore University Hospital
300 Community Drive
Manhasset, NY 11030
Martin Fisher
Program Director
JH 0; SH

Jamaica Hospital
8906 135th Street
Jamaica, NY 11418
Susan Ulrich, N.P.
JH 0; SH 1

Bronx-Lebanon Hospital
1650 Grand Concord
Bronx, NY 10457
Constance Garcia
Program Administrator
JH 0; SH 1

New York Medical College
Munger Pavilion
Division Adolescent Medicine
Valhalla, NY 10595
Steven Tames, M.D.
JH 0; SH 1

NORTH CAROLINA

Robeson County Dept. of Health
Rt. 4, Box 388
Lumberton, NC 28358
Rachel Britt, RN
JH 1; SH 1

Guilford County Dept. of Public Health
300 E. Northwood St.
Greensboro, NC 27402
Jane Foy, M.D.
Director
JH 0; SH 1

OHIO

Cleveland Student Health Program
1001 Huron Road
Cleveland, OH 44115
Victoria Thompkins
Executive Director
JH 0; SH 1

OREGON

Jackson County Health Dept.
1313 Maple Grove Drive
Medford, OR 97501
Patti Lane
Nursing Coordinator
JH 0; SH 1

Eugene School District 4-J
200 N. Monroe St.
Euguene, OR 97402
Pat Nichols
JH 0; SH 1

Oregon Health Science University
School Of Nursing
Hunt H1 304B
La Grande, OR 97850
Marcia Shoup
Director,
EOSC Campus
JH 0; SH 1

Lincoln County Health Dept.
255 S. W. Coast Hwy.
Newport, OR 97365
Cheryl Siminois
Program Coordinator
JH 0; SH 1

Multnomah County Health Dept.
426 Southwest Stark, 8th. Flr.
Portland, OR 97204
Anne Cathey
Program Coordinator
JH 0; SH 1

PENNSYLVANIA

Greater Philadelphia Health Action
4510 Frankford Ave.
Philadelphia, PA 19124
Judy Stavisky
JH 0; SH 1

RHODE ISLAND

Providence Ambulatory Health
Care Foundation
469 Angel St.
Providence, RI 02906
Arlene Greene, RN
JH 1; SH 0

SOUTH CAROLINA

Denmark-Olar School District
P. O. Box 345
Denmark, SC 29402
Stanley Ross
Director
JH 0; SH 1

TENNESSEE

Memphis/Shelby County Health Dept.
814 Jefferson Avenue
Memphis, TN 38105
K. Johnston, RN, or Hugh Barnes
Administrator
JH 0; SH 2

Metropolitan Health Department
311 23rd Ave. North
Nashville, TN 37203
Diane Pincus, M.D.
JH 0; SH 1

TEXAS

Dallas Children and Youth Project
3131 W. Hampton
Dallas, TX 75212
Truman Thomas
Director
JH 0; SH 1

Urban Affairs Corp.
2815 Reid Street
Houston, TX 77026
Donna Bryant
JH 0; SH 1

VIRGINIA

Planning Council
130 W. Plume St.
Norfolk, VA 23510
Mary Louis Campbeli
JH 0; SH 1

WISCONSIN

Milwaukee Comprehensive
Community Health, Inc.
1747 N. 6th St.
Milwaukee, WI 53212
Pat McManus
Project Director
JH 0; SH 1

Sharon R. Lovick
Director

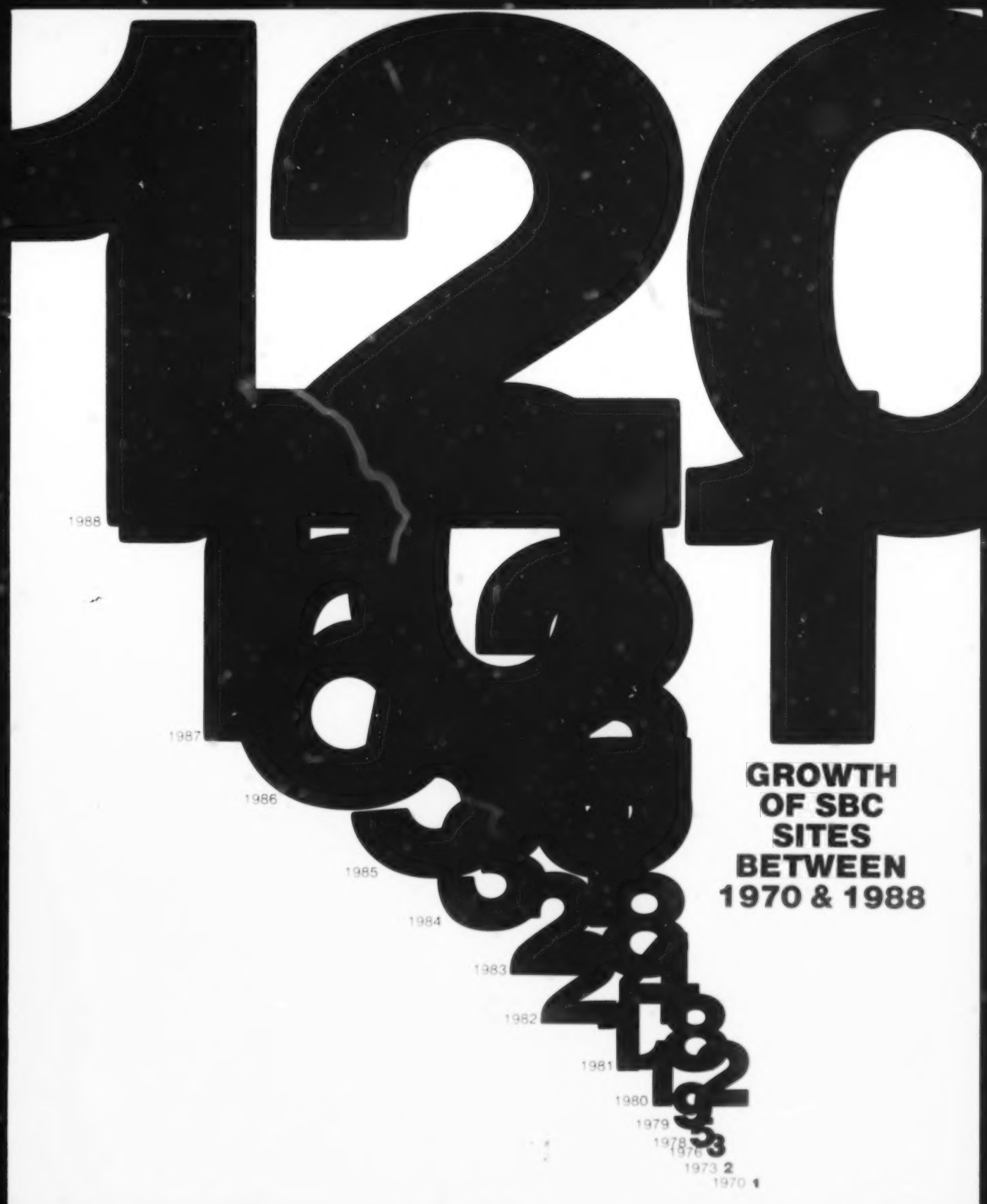
Renee Freedman Stern
Program Associate

Mary E. Garza
Administrative Associate

The Support Center for
School-Based Clinics
5650 Kirby Drive
Suite 203
Houston, Texas 77005

Judith Senderowitz
Executive Director

The Center for
Population Options
1012 – 14th St., N.W.
Washington, D.C. 20005


120
1988
1987
1986
1985
1984
1983
1982
1981
1980
1979
1978
1976
1973
1970
GROWTH
OF SBC
SITES
BETWEEN
1970 & 1988

69%

1988